CAP-MR/DD Residential Supports (RS)
Endorsement Check Sheet Instructions

Introduction

Prior to site and service endorsement, business verification must take place. During the process of business verification, the provider organization submits a self study of the core rules (10A NCAC 27G .0201-.0204) verifying that they have met all the requirements therein. (The provider is not required to submit this if nationally accredited, licensed with DFS or has had a compliance review from NC Council of Community Programs within the past three years.) The documents created in adherence with the core rules should be utilized as evidence of provider compliance where noted in the check sheet and instructions.

The following set of instructions is to serve as general guidelines to facilitate the review of providers for endorsement. Service definitions, core rules (as noted above), staff definitions (10A NCAC 27G .104) and other DHHS communications (e.g. Service Records Manual, Communication Bulletins, Implementation Updates and other publications) should be used to support the reviewer's determination of compliance. In addition, the Business Entity Type Reference document (attached) assists to clarify the requirements for different business entities such as corporations, partnerships and limited liability corporations and partnerships.

Provider Requirements

In this section, the provider is reviewed to ascertain that requirements are met in order for services to be provided. The provision of services is addressed later in this endorsement process.

1. a-d Review identified documents for evidence that provider meets DMH/DD/SAS and/or DMA standards as related to administration responsibilities, financial oversight, clinical services and quality improvement. These standards include, but are not limited to, policies and procedures (contents of which are mandated in 10A NCAC 27G .0201 – Governing Body Policies) and the key documents required by law for the formation of the business entity (refer to attachment titled Business Entity Type).

Review documentation that demonstrates provider is a legal US business entity. Documentation should indicate the business entity is currently registered with the local municipality **or** the office of the NC Secretary of State, that the information registered with the local municipality **or** the Secretary of State is current, and that there are no dissolution, revocation or revenue suspension findings currently attached to the provider entity. Also review corporate documentation demonstrating registration to operate a business in NC. Information for corporate entities may be verified on the web site for the Secretary of State. (Refer to key documents section of attachment titled Business Entity Type.)

Review the documentation that demonstrates the provider has been accredited by a designated accreditation agency. Evidence of formal application to a DMH-DD-SAS accepted National Accreditation body (prior to Nov. 1, 2009) or Certificate of National Accreditation (by Nov. 1, 2009 or 1 yr post provider enrollment date)

- Has the provider attained National Accreditation? If so review the actual Accreditation Document.

- If not, what is the provider plan to attain National Accreditation? Review for evidence that the provider has selected an Accrediting agency or has evidence of official intent with an Accrediting agency

2. Staffing Requirements

2. a-h In this section, the reviewer is primarily concerned with the hiring practices of the provider and ensuring that all employees in place are equipped with the education, training and experience to work with the population served in the capacity and at the level of intervention for which they were hired. Staff providing the service of Residential Supports must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. In addition, the staff must meet client specific competencies as identified by the participant's person centered planning team and documented in the Person Centered Plan/Plan of Care. These requirements must be met as outlined in the CAP-MR/DD waiver approved by the Centers for Medicaid and Medicare.

Review personnel files; supervision plans or other documentation that staff minimum requirements and supervision requirements are met. Review the job description for paraprofessionals and review the program description and personnel manual to determine the role and responsibilities of such staff and the expectation regarding supervision. Review the following for each paraprofessional:

- Employment application,
- Resume, and
- Other documentation for evidence of at least a GED or high school diploma. Existing staff must have documentation of either High School diploma/GED or b) they will have 18 months to obtain their GED upon implementation of the waiver. All new staff (hired post implementation) must have proof of High School Diploma or GED upon hire at implementation of the waiver.
- Client Specific Competencies Trainings
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training

Each paraprofessional must have an individualized supervision plan that is carried out by a Qualified Professional or an Associate Professional. Review supervision plans to ensure that each paraprofessional is receiving supervision and review notes, schedule and other supporting documentation that demonstrate on-going supervision by the Qualified Professional or Associate Professional. In addition, the Person Centered Plan/Plan of Care must be reviewed to determine the client specific competencies to be addressed for the participant. Review of personnel files should include review of:

- Documentation verifying criminal record check
- Healthcare registry check
- Driving record must be checked if providing transportation and copy of driver's record.
- Have a valid North Carolina or other valid driver's license and copy of license.
- Have an acceptable level of automobile liability insurance (copy of insurance and registration)

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3. Service Type/Setting

3.a-f Residential Supports is provided in a facility which is integrated in the community and has a home and community environment. Home and community environment is characterized as a facility that provides an environment like a home, provides full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, provides for privacy, visitors at times convenient to the participant and easy access to resources and activities in the community.

Residential Supports is provided to participants who reside in licensed residential settings with 3 or less beds or unlicensed alternative living arrangements (AFL) serving one adult. Review of appropriate license or the presence of a health and safety check using the Division of MH/DD/SAS health safety review check sheet must occur.

Residential Supports may also be provided in licensed residential setting of 4-6 beds which were licensed prior to the implementation of this waiver and demonstrate a home and community character.

Participants who live in a licensed group home or adult care home with 7-15 beds, and who were participating in the CAP-MR/DD Waiver (North Carolina's approved 1915-C Home and Community Based Waiver) at the time of implementation of this Waiver may continue receiving Residential Supports in their current living arrangement, if it is justified in the Person Centered Plan/Plan of Care as to the appropriateness of this placement, the unavailability of other appropriate placements and how this placement meets the home and community character. No other participants may receive CAP-MR/DD waiver services in a licensed group home or adult care home with 7-15 beds, except for participants admitted only for short term respite.

Participants who live in residences with 16 or more beds at the time of the implementation of this Waiver may continue receiving Residential Supports in their current living arrangement however these participants will be transitioned into smaller community based living arrangements within three years of the implementation of this waiver. Plans for this transition must be developed within 6 months of the implementation of the waiver. A progress report outlining activities completed toward transition must be accompanied with each Person Centered Plan/Plan of Care and request for reauthorization of services. No other participants will receive CAP-MR/DD waiver services in residences of 16 or more beds.

4. Program/Clinical Requirements

The elements in this section pertain to the provider's having an understanding of the Residential Supports (RS) service.

4.a.-g. Review program description which should reflect a blended service that includes training and habilitation as well as support, care, and supervision through the course of the person's day when not engaged in structured day programming. Program description should reflect that not only habilitation is provided but that support, care, and supervision is provided on an as needed basis through the course of the person's day when not engaged in structured day programming.

Observe program activities to verify that they are consistent with the above. Review the participant's Person Centered Plan/Plan of Care to insure that outcomes related to residential and community living are included and service notes to verify that the programming is consistent with participant needs (as indicated in the Person Centered Plan/Plan of Care).

5. Service Limitations:

5.a-b Review program description as well as billing records to verify that billing of RS does not include payment for room and board, nor payments made directly or indirectly to members of the participant's immediate family. In addition, program descriptions and billing record review should also include verification that payment is not made for the routine care and supervision that would be expected to be provided by family or group home provider, or for activities a or supervision for which a payment is made by a source other than Medicaid. Review program description and billing records to verify that payment is not made for State Plan Adult Care Personal Care Services, Home Supports or waiver Personal Care since personal care is included in the definition of RS.

Review program description, policies and procedures, and billing records to verify that only the community component of Home and Community Supports (HCS) is used with RS to meet the day programming needs of participants who have chosen not to receive their day programming needs through a licensed facility.

Observe program activities to verify that they are consistent with the above and to insure that outcomes related to residential and community living is included. Review service notes to verify that the programming is consistent with the above as well as participant needs (as indicated in the Person Centered Plan/Plan of Care).
Participants who receive Residential Supports may not receive State Plan Adult Care Personal Care Services, Medicaid Personal Care Service, Home and Community Supports or Personal Care Services.

Documentation Requirements

All three components of Residential Supports - Habilitation, Personal Care, and Support - shall be addressed in the documentation. A grid has been developed specifically for documentation of Residential Supports, and includes a grid page for habilitation activities, as well as a combination checklist and service note page to address personal care and support activities. The habilitation aspect of the service may be noted by using a grid; however, personal care and support may be addressed by either using a grid, checklist, or daily note.

Review the provider's Policy and Procedure Manual to verify that documentation requirements are consistent with requirements noted above. Review service notes to verify that documentation is consistent with requirements.

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